Introduction

Procedure Codes

The Health and Recovery Services Administration (HRSA) uses the following types of procedure codes within these *Physician-Related Services Billing Instructions*:

- Current Procedure Terminology (CPT®); and
- Level II Healthcare Common Procedure Coding System (HCPCS).

Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all HRSA-covered services. **Due to copyright restrictions, HRSA publishes only the official brief CPT descriptions. To view the full CPT description, please refer to your current CPT manual.**

Diagnosis Codes

HRSA requires valid and complete ICD-9-CM diagnosis codes. When billing HRSA, use the highest level of specificity (4th or 5th digits when applicable) or the services will be denied.

HRSA does not cover the following diagnosis codes when billed as the primary diagnosis:

- E codes (Supplementary Classification);
- M codes (Morphology of Neoplasms); and
- Most V codes.

HRSA reimburses providers for only those covered procedure codes and diagnosis codes that are within their scope of practice.

Grace Period for Discontinued Codes

HRSA follows Medicare's policy in eliminating the grace period for discontinued CPT and HCPCS procedure codes and ICD-9-CM diagnosis codes.

Noncovered Services **[WAC 388-531-1900]**

Procedures that are noncovered are noted with a pound (#) indicator in the Nonfacility Setting (NFS) and Facility Setting (FS) columns in the fee schedule.

If a client has extenuating medical circumstances that are not covered under the client's HRSA program and the medical provider feels HRSA should take these into consideration for coverage, the provider must submit a written request to HRSA for approval. Send a completed "Fax/Written Request Basic Information" form [DSHS Form #13-756] to HRSA (see *Important Contacts* section).

The following are examples of administrative costs and/or services not covered separately by HRSA:

- Missed or canceled appointments;
- Adult preventive exams (except EPSDT exams for clients 20 years of age and younger and those clients with developmental disabilities);
- Mileage;
- Take-home drugs;
- Educational supplies or services;
- Copying expenses, reports, client charts, insurance forms;
- Service charges/delinquent payment fees;
- Telephoning for prescription refills;
- Other areas as specified in this fee schedule;
- After-hours charges for services during regularly scheduled work hours.

Noncovered Practitioners [WAC 388-531-0250]

HRSA does not reimburse for services performed by any of the following practitioners:

- Acupuncturists;
- Naturopaths;
- Homeopathists;
- Herbalists;
- Masseurs, masseuses;
- Christian Science practitioners or theological healers;
- Counselors (i.e., M.A. and M.S.N.);
- Sanipractors;
- Those who have a master's degree in social work (M.S.W.), except those employed by an FQHC or who have prior authorization to evaluate a client for bariatric surgery;
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010;
- Any other licensed practitioners providing services that are not within the scope of the practitioner's license; and
- Any other licensed practitioners providing services that the practitioner is not trained to provide.

Clients Enrolled in HRSA's Managed Care Organizations

Many HRSA clients are enrolled in one of HRSA's managed care organizations (MCO). These clients have an HMO identifier in the HMO column on their DSHS Medical ID Card. They also receive an ID card from the MCO in which they are enrolled. Clients enrolled in one of HRSA's MCOs must obtain services through their MCO.

> **Note:** A client's enrollment can change monthly. Prior to serving a managed care client, make sure you receive approval from ***both*** the plan and the client's primary care provider (PCP), if required.

Send claims to the client's MCO for payment. Call the client's HMO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 388-502-0160.

By Report (BR)

Services with a **BR** indicator in the fee schedule (Section J) with billed charges of $1,100.00 or greater require a detailed report in order to be paid. Attach the report to the claim. **DO NOT** attach a report to the claim for services with a BR indicator in the fee schedule with billed charges under $1,100.00 unless requested by HRSA.

Acquisition Cost (AC)

Drugs with an **AC** indicator in the fee schedule (Appendix) with billed charges of $1,100.00 or greater, or supplies with billed charges of $50.00 or greater, require a manufacturer's invoice in order to be paid. Attach the invoice to the claim, and if necessary, note the quantity given to the client in the *Comments* section of the claim form. **DO NOT** attach an invoice to the claim for procedure codes with an AC indicator in the fee schedule for drugs with billed charges under $1,100.00, or supplies with billed charges under $50.00, unless requested by HRSA.

Note: Bill HRSA for one unit of service only.

Conversion Factors

	7/1/01	7/1/02	7/1/03	7/1/04	7/1/05	7/1/06
Maternity	$45.34	$45.59	$45.59	$44.46	$44.99	$44.71
Anesthesia	$15.49	$15.70	$20.23	$20.24	$20.44	$20.99
Children's Primary Health Care	$36.52	$35.62	$35.62	$34.25	$34.56	$35.00
Adult Primary Health Care	$21.27	$20.44	$25.00	$25.00	$24.82	$25.51
All Other Procedure Codes	$22.41	$22.75	$22.75	$22.67	$22.71	$22.93
Clinical Lab Multiplication Factor	.720	.719	.810	.797	.820	.820

These conversion factors multiplied by the Relative Value Units (RVUs) establish the rates in this fee schedule.

National Correct Coding Initiative

HRSA continues to implement the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists HRSA to control improper coding that may lead to inappropriate payment. HRSA bases coding policies on:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual;
- National and local policies and edits;
- Coding guidelines developed by national professional societies;
- The analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

HRSA may perform a post-pay review on any claim to ensure compliance with NCCI. Visit the NCCI on the web at http://www.cms.hhs.gov/physicians/cciedits.

This page intentionally left blank.